

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 8 1948

Registration District No. 128

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 2000

32631

State File No.

Registrar's No. 941

1. PLACE OF DEATH:

(a) County Greene
 (b) City or town Springfield
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Burge Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Sept. 26, to Oct. 29
 (Specify whether
 In this community 70 yrs.
 years, months or days)

3. (a) PRINT FULL NAME Marion Thomas

3. (b) If veteran, name war no
 3. (c) Social Security No. no

4. Sex M D 5. Color or race W
 6. (a) Single, widowed, married, divorced, widowed
 6. (b) Name of husband or wife Lana
 6. (c) Age of husband or wife if alive, years 31
 7. Birth date of deceased Oct 31, 1869
 (Month) (Day) (Year)

8. AGE: Years 78 Months 11 Days 28
 If less than one day hr. min.

9. Birthplace Lebanon MO.
 (City, town, or county) (State or foreign country)

10. Usual occupation Retired Fruit Farmer

11. Industry or business Fruit R. R.

12. Name E. H. Thomas
 13. Birthplace Unknown
 (City, town, or county) (State or foreign country)
 14. Maiden name Amanda Lillard
 15. Birthplace Lebanon MO.
 (City, town, or county) (State or foreign country)

16. (a) Informant R. E. Thomas
 (b) Address Springfield MO.
 17. (a) Burial (b) Date thereof 10-31-48
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn

18. (a) Signature of funeral director J. W. Klingner & Co.
 (b) Address Springfield

19. (a) 11-1-48 (b) W. J. Hunsicker MD
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene
 (c) City or town Springfield
 (If outside city or town limits, write "RURAL")
 (d) Street No. 2554 N. Grant
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 29
 year 1948 hour 5 minute 40 a.m.

21. I hereby certify that I attended the deceased from May 1948 to 29 October 1948
 that I last saw him alive on 28 October 1948
 and that death occurred on the date and hour stated above.

Immediate cause of death Obstruction, Intestinal
 Duration 1 WK

Due to Carcinoma Colon Ascending
& Metastasis

Due to 46E
 Other conditions (Include pregnancy within 3 months of death)

Major findings: Carcinoma (tumor mass)
 Of operations Ascend. Colon. Iliocolicotomy
at State (Mo.) Cancer Hospital 1947.
 Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) No
 (b) Date of occurrence None
 (c) Where did injury occur? None
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work (Specify type of place) (e) Means of injury 0

23. Signature of Newton Wakeman (M. D. or other)
Springfield, Mo. Date signed 29 Oct 48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Ogle Stone Jr.

Licensed Embalmer No. *4176*

P. O. Address.....

Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.